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ABOUT THE ORGANISATIONS

This report has been prepared by **SECTION27** in partnership with the **Treatment Action Campaign (TAC)**.

SECTION27 is a public interest law centre that seeks to achieve substantive equality and social justice in South Africa. Guided by the principles and values of the Constitution, SECTION27 employs law, advocacy, legal literacy, research and community mobilisation to advance access to healthcare services and basic education.

> SECTION27 aims to achieve structural change and accountability to ensure the dignity and equality of everyone.

SECTION27 focuses on the reproductive health rights of women, including access to abortion, through advocacy and the provision of legal support to women seeking abortion services.

The Treatment Action Campaign (TAC) is a membership-based organisation that, through its branches and members, monitors thousands of clinics and hospitals throughout South Africa.

> By organising locally, the TAC is able to demand accountability and quality healthcare services at public health institutions. In addition to monitoring, TAC campaigns, litigates and advocates on critical issues related to the quality of and access to healthcare.

Glossary of important terms and concepts

Women: references to women in this report refer to all women, girls and persons born with a uterus.

EXECUTIVE SUMMARY

South Africa is well known for its progressive legal frameworks with respect to abortion. Unfortunately, despite this, patterns of exclusion in maternal healthcare remain profound.[1] By and large, access to abortion services has increased among women in metropolitan areas in South Africa. However, those living outside major urban centres and in rural provinces have not benefited to the same degree.[2] The right to a safe, legal abortion in South Africa – especially for poor, black and rural women – remains unrealised.[3] Moreover, designated facilities for the provision of medical abortion are not available nationwide.[4]

> *The right to a safe, legal abortion in South Africa – especially for poor, black and rural women – remains unrealised.*

Since 2019, SECTION27 and TAC have monitored and assessed access to abortion services in the Eastern Cape, with monitoring extended to Limpopo in 2024. This report follows the analysis of abortion access in the Eastern Cape conducted by SECTION27 and the TAC in 2022 and serves as a continuation of our assessment of the state of abortion services as set out in our initial report, 'The State of Abortion Services in the Eastern Cape 2022'.

This report provides an analysis of the barriers to abortion services identified through facility monitoring conducted by SECTION27 and TAC in the Eastern Cape and Limpopo in 2024. The purpose of the facility monitoring was to conduct field research on the state of abortion services at public health facilities and, in so doing, provide an assessment of the accessibility of abortion services at designated facilities in the two provinces. Overall, this report documents the failure to ensure the progressive realisation of the right to access to reproductive healthcare for women in the Eastern Cape and Limpopo by the National Department of Health, Eastern Cape Department of Health, and Limpopo Department of Health. The three departments have failed to take adequate legislative and other measures to provide adequate access to, and remove barriers to, termination of pregnancy (TOP) services. The report identifies the following barriers to access to abortion services:

Barriers to Access:

- lack of availability and / or operation of designated facilities
- delays in care
- the arbitrary practice of conscientious objection in a discriminatory and unregulated manner
- an insufficient number of abortion providers to meet demand for the service
- a lack of equipment for the timely provision of the service
- shortages of abortion medicines.

Notably, our research reveals that there is a dire shortage of second-trimester facilities in both provinces, resulting in disproportionate demand on the few facilities that do provide second-trimester abortions. In instances where women cannot afford (or are otherwise unable) to travel to the operational second-trimester facilities, they may turn to unsafe abortion providers.

[1] C Albertyn "claiming and defending abortion rights in South Africa" (2015) Revista Direito GV, 11(2), 429-454.
[2] Ibid.
[3] Amnesty International "Briefing: Barriers to Safe and Legal Abortion in South Africa" (2017) available at https://amnesty.org.za/wp-content/uploads/2018/06/Womens-rights-Briefing-Barriers-to-Safe-and-Legal-Abortion-in-South-Africa-2017_Web.pdf
[4] Ibid.

APPROACH AND METHODOLOGY

The monitoring was prompted by numerous complaints from women who were unable to access abortion services at their nearest clinics or hospitals. Many were referred to the nearest facility providing the service, often located as far as 30km, and up to 300km away. In several cases, women were referred to facilities in other districts, only to arrive and find that no services were being provided due to, among other things, a shortage of providers willing to perform abortions, leaving them without the care they urgently required. Monitoring has been conducted through telephonic hot-spotting, physical visits to designated facilities and interviews with patients and providers. Prior to the visits to public abortion facilities in the respective provinces in 2024, SECTION27 wrote to the relevant district health managers requesting that authorisation be provided to facility managers and abortion providers at facilities to engage with SECTION27 during the monitoring process. This authorisation was obtained and communicated to the relevant public health facilities. While not all district health managers responded to our requests, several provided the necessary authorisation, which enabled access to abortion facilities and staff.

> *Many were referred to the nearest facility providing the service, often located as far as 30 km to 300 km away.*

Bearing in mind the widely reported acrimonious and combative experiences that women face at abortion facilities, the team initially observed from afar the treatment women received when they approached public health facilities to request an abortion, before introducing ourselves. This was done to ensure that the information provided to us by the abortion providers and facility managers we approached during our research accurately represented the realities women face when they attend these facilities.

Once we had assessed the conditions at the facility and the treatment received by women requiring abortions, we introduced ourselves and conducted interviews with abortion providers and the management of the various healthcare facilities. We also interviewed women who had approached the facilities to obtain an abortion.

RESEARCH LIMITATIONS

Despite the cooperation of many stakeholders, including district health managers, healthcare providers and users, there were several limitations to the data collected. SECTION27 did not receive responses from some district health managers, and this resulted in some facilities and healthcare providers refusing the team access. Additionally, some healthcare users could not be interviewed due to fear of stigma and privacy concerns.

LEGAL AND POLICY FRAMEWORK REGULATING ABORTION IN SOUTH AFRICA

The South African Constitution guarantees the right to access healthcare services, including reproductive healthcare.[5] Furthermore, the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies.[6]

To give effect to the constitutionally guaranteed right to reproductive healthcare, the Choice on Termination of Pregnancy Act (CTOP Act) was enacted in 1996.[7] The CTOP Act constitutes the legislative framework enacted to give effect to the constitutional rights of women to make autonomous decisions regarding their reproductive health.[8] The Act affirms the right to access termination of pregnancy services within a regulated legal and medical context, thereby promoting the protection of reproductive health, dignity and bodily integrity in accordance with the values of the Constitution.[9]

In 2020, the National Department of Health introduced the National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy ('Guideline'). The Guideline aims to ensure accessible, equitable and cost-effective abortion services.

The Guideline provides guidance to all public and private healthcare workers and facilities. This includes national, provincial and district health officials, health facility managers, healthcare workers and any other organisations involved in the provision of abortion care, including the provision of abortion-related information and counselling.

The Guideline outlines the circumstances and places in which termination of pregnancy may take place in line with the Act. It further provides operational guidance on obstruction of access and sets out how conscientious objection should be regulated. The Guideline is periodically updated to align with the World Health Organization's Abortion Care Guidelines ('WHO Guidelines').

The World Health Organization periodically releases abortion care guidelines aimed at integrating human rights into healthcare programmes and policies at national and regional levels by looking at the underlying determinants of health as part of a comprehensive approach to health and human rights. The recommendations and best practices described in the Guideline aim to enable evidence-based decision-making with respect to quality abortion care. It is against this standard that South Africa's progress in delivering quality abortion services must be assessed.

[5] Constitution of the Republic of South Africa, section 27.
[6] Constitution section 12.
[7] Choice of Termination of Pregnancy Act 92 of 1996.
[8] Ibid, Preamble.
[9] Ibid, Preamble.

KEY FINDINGS

> *Overall, SECTION27's research reveals that women in Limpopo and the Eastern Cape encounter significant barriers that deprive them of the agency to realise their rights to reproductive healthcare.*

Fifteen facilities were monitored in the Eastern Cape across three districts, namely Sarah Baartman District, Joe Gqabi District and Alfred Nzo District. In Limpopo, 65 facilities were monitored across five districts, namely Capricorn District, Sekhukhune District, Vhembe District, Waterberg District and Mopani District.

Overall, the research reveals that women in Limpopo and the Eastern Cape encounter significant barriers that deprive them of the ability to realise their rights to reproductive healthcare. The report findings are grouped thematically, as some are common across the monitored facilities, while others are common to only a few facilities. In each instance, the affected healthcare facilities are named under the relevant themes.

65 facilities visited in Limpopo

Only **31** meet requirements

Only **21 facilities** currently providing TOP services

1. Availability of facilities

Termination of pregnancy can only be lawfully performed at a facility designated by the MEC and at healthcare facilities that have a 24-hour maternity service; facilities with 24-hour maternity services do not require designation by the MEC to provide abortion services.[10] The CTOP Act sets out the infrastructural and clinical requirements for facilities where terminations of pregnancy may lawfully be performed. It provides that such procedures must take place only in facilities that are adequately equipped to ensure the safety and wellbeing of the patient. These facilities must offer access to qualified medical and nursing staff, possess an operating theatre, and appropriate surgical equipment, and be capable of administering intravenous and intramuscular medication. The facility must have emergency resuscitation equipment, access to an emergency referral centre and the means to transport patients in the event of an emergency. It must also provide for clinical observation, access to in-patient care, effective infection control, safe waste disposal and reliable telephonic communication.[11]

In Limpopo, the research team visited 65 facilities, with 52 of those facilities listed as designated to provide abortion services on the Limpopo Department of Health's website. The monitoring exercise revealed that only 31 facilities meet the clinical and infrastructural requirements to be designated as facilities providing abortion services. Eleven of the 31 facilities had suspended abortion services indefinitely pending the replacement of an abortion provider. As a result, only 21 facilities are providing abortion services in the entire Limpopo province.

In the Capricorn District, five out of 11 facilities visited provide abortion services. There is no second-trimester facility in the district and users are advised to attend antenatal classes or consult a private doctor if they are above 12 weeks' gestation. In Waterberg, the team visited 16 facilities, and nine facilities provided abortion services. Three of the nine facilities provide second-trimester abortion services.

[10] Ibid, section 3.
[11] Ibid, section 3(3).

Facilities

Shortage

Suspended services

District gaps

In Vhembe, 14 facilities were monitored and only six facilities offer abortion services. In Mopani District, the team visited about 18 facilities and seven confirmed that they offer abortion services. Finally, in Sekhukhune, 10 facilities were monitored and only four confirmed that they offer abortion services.

> *There are only three facilities providing second-trimester abortion services in the entire province - all three are situated in Waterberg District.*

Similarly, the Eastern Cape also has only three second-trimester TOP facilities.

In the Eastern Cape, services had been discontinued at three of the 15 facilities monitored.

> *The findings above indicate a severe shortage of equipped facilities available for women seeking access to abortion services in the two provinces with the largest share of women in South Africa's total population.*

The findings also show an inconsistency between the designated facilities reported by the two departments and the reality on the ground.

[12] Abortion care guideline. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
[13] Ibid page 40.

2. Delays in care and mandatory waiting periods

Although the CTOP Act does not explicitly regulate formal waiting periods for the provision of abortion services, systemic barriers create significant delays, resulting in mandatory waiting periods being imposed on those seeking abortion services. Due to a myriad of systemic issues, women in rural areas are forced to wait for weeks and even months to access abortion services after their first consultation. The situation is particularly dire at second-trimester facilities, where waiting periods can range from five to seven weeks from the initial consultation.

The delays in care can be attributed to the numerous systemic issues facing the healthcare system, including capacity constraints, inefficient referral systems and equipment shortages. Delays caused by systemic barriers inflict severe harm on women in underserved areas, disproportionately affecting their access to reproductive healthcare. SECTION27 has documented instances in which women are forced to travel more than 100 kilometres to access abortion facilities due to the lack of second-trimester facilities near their areas of residence.

The WHO Guidelines emphasise the importance of timely access to abortion care, stating that "all eligible patients must be offered timely, equitable and comprehensive abortion services".[12] The WHO Guidelines further emphasise that waiting periods - whether formally mandated or resulting from systemic barriers - violate international human rights standards.[13] Delays in access to abortion services disproportionately harm economically disadvantaged groups, young women and rural residents, thereby exacerbating inequities in healthcare access.

3. Conscientious objection

Women and girls are denied access to TOP services in an arbitrary and discriminatory manner under the guise of conscientious objection.

SECTION27's research and casework have demonstrated that women are denied access to termination of pregnancy because healthcare practitioners assigned to provide abortion services refuse to provide care. This is facilitated by the National Department of Health's failure to regulate conscientious objection.

The CTOP Act neither defines nor makes provision for conscientious objection or refusal to care. The Act refers to obstruction of access and provides that any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.[14]

The Guideline introduced the notion of refusal to care on conscientious grounds. According to the Guideline, refusal to care refers to individuals who prevent a lawful termination of pregnancy or obstruct access to a facility for a lawful termination of pregnancy on the basis of personal beliefs, usually religious or spiritual in nature.

The Guideline grounds the implicit accommodation of providers' refusal to care in section 15(1) of the Constitution, which states that "everyone has the right to freedom of conscience, religion, thought, belief and opinion".[15] In the same section, the Guideline acknowledges that refusal to care creates harm and additional barriers for patients who are entitled to receive comprehensive sexual and reproductive health services and rights.[16]

The Guideline aims to regulate how objections should be raised by setting out a standard protocol to be followed in non-emergency cases. In terms of the Guideline, only the direct abortion provider may refuse care; this does not allow for other healthcare or support staff to refuse to provide care.[17] Ancillary staff, including receptionists and security personnel, and other healthcare professionals involved in the general care of a patient, such as pharmacists, may not refuse to provide general or standard care to an individual under any circumstances.[18]

Accordingly, a direct abortion provider who refuses care on the basis of personal beliefs must refer the individual to a colleague or facility that is able to offer such services.[19] The individual's right to information and access to healthcare services, including abortion, must always be respected.[20]

In the case of a direct provider's refusal to care, a standard protocol should be followed:

Standard protocol for refusal to care:

- The healthcare provider must provide the individual with information about where the individual can obtain a abortion and refer the individual accordingly.
- A register of abortion services refused should be kept in each facility, noting the clinical details of the individual, the referral process and the name of the clinician who refused service.[21]

[14] Choice of Termination of Pregnancy Act section 10 (c).
[15] National Clinical Guidelines for Implementation of the Choice on Termination of Pregnancy page 6.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.

Healthcare professionals who refuse to provide abortion services must still explain their refusal to the individual in a manner that is non-judgemental and non-stigmatising. They must explain the individual's right to request a safe abortion, refer the individual to a facility or provider who will conduct the abortion and update the facility register to record the refusal to treat.[22]

> *A healthcare professional cannot legally or ethically object to rendering care in cases of life- or health-endangering emergencies associated with abortion procedures.*

Healthcare professionals, regardless of their religious or moral objections, have a duty to perform a abortion procedure if the individual will suffer adverse health consequences if the procedure is not promptly carried out.[23]

The socio-economic and geographical landscape in the country exposes women to varying experiences when seeking abortion services. Young black women from poor socio-economic backgrounds residing in rural areas are most often on the receiving end of the shortcomings in the regulation of conscientious objection by the National Department of Health, as evidenced below.

[22] Ibid.
[23] Ibid.

SECTION27 has observed the following:

- Women and girls are denied access to abortion services in an arbitrary and discriminatory manner under the guise of conscientious objection.
- Some objectors decide whether to provide abortion services on a case-by-case basis, depending on their view of a woman's reason for seeking a abortion, which means availability is neither clear nor consistent.
- Objections are practised in a judgemental and punitive manner.
- Ancillary staff members refuse access to care.
- Objectors' referral practices are highly variable - some may refer only on a case-by-case basis, and referral pathways may be circuitous and burdensome.
- No referral protocols are in place.
- Objections result in mandatory waiting periods or the denial of access to safe and timely abortion.

During our research, we encountered several women who required access to abortion services. We observed healthcare workers refusing to provide abortions to these women on the basis of conscientious objection. Their objection was practised in a judgemental and punitive manner, and in most instances, they berated women for seeking abortion services in an apparent effort to humiliate them, presumably into backtracking on their decision to terminate their pregnancies.

Case example

In June 2024, SECTION27 assisted a minor who was 19 weeks pregnant and seeking access to second-trimester abortion services. SECTION27 referred the accompanied minor to Cecilia Makiwane Hospital, one of only three hospitals conducting second-trimester abortion procedures in the Eastern Cape. On the day of her appointment at the hospital, all the nurses providing abortion services stayed away from work in protest against providing the required service to the client. The group of nurses based their refusal to care for this client on conscientious objection relating to the client's age and the gestational age of the pregnancy, despite it being within the time limits allowed by law for an abortion.

The objection was communicated to the client with no referral to another facility - it was only after SECTION27 intervened that the client was transferred to Frere Hospital. At Frere Hospital, the client was subjected to further discrimination and stigma due to her age and her decision to terminate the pregnancy. The nurses at Frere Hospital refused to provide care to the client and instructed her to self-administer the medication that induced the abortion. The refusal to care was exercised in an arbitrary and discriminatory manner. As a result of the refusal to care by the designated staff at the hospital, the client was instructed to self-administer abortion medication with no supervision or care. Following self-administration of the medication, the client bled excessively, requiring a blood transfusion. The client also showed signs of sepsis due to foetal contents not being removed from her uterus following the expulsion of the products of conception, and she had to be placed on a course of antibiotics.

The above case is one of many that demonstrate facilities' failure to enforce the regulation of refusal to care in an appropriate manner. The case further illustrates the real-life implications of the state's failure to balance competing rights.

During monitoring, abortion providers reported issues related to refusal to care, including doctors refusing to prescribe medication for patients seeking an abortion, short staffing at facilities due to nurses and doctors objecting to providing abortion services, and abortion providers lacking support due to alienation by colleagues and management.

The WHO Guidelines recommend that access to, and continuity of, comprehensive abortion care be protected against barriers created by conscientious objection. The WHO Guidelines further state that if it proves impossible for a State to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible.[24]

[24] Abortion care guideline. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO. 60

4. Regulation of consent

An abortion may only take place with the informed consent of the pregnant woman, and no consent other than that of the pregnant individual is required, irrespective of age.[25] However, SECTION27 continuously receives cases of facilities requesting third-party consent as a prerequisite for providing abortion services. This is mainly the case with minors seeking access to abortion services. This practice is not only in contravention of the Act but also contrary to international best practice.

> The WHO Guidelines emphasise that abortion should be made available at the request of the pregnant individual without requiring external authorisation. The WHO Guidelines further caution against administrative or procedural barriers that create delays, stating: "Mandating external authorisation for abortion care is discriminatory, delays care and violates human rights standards."[26]

5. Equipment constraints

As mentioned above, facilities designated to provide lawful terminations must meet the infrastructural requirements set out in the CTOP Act. A key observation at the monitored facilities was the lack of physical space designated for abortion services within the facilities. It is common to find abortion units placed at the back of maternity wards, with insufficient space for clinical observation and private counselling. Two of the facilities visited in the Eastern Cape, namely Andries Vosloo Hospital and Midlands Hospital, indicated that there is no designated space for abortion services within the facilities. Similarly, many of the facilities in Limpopo, including Seshego Hospital, LLT Memorial Hospital, Rethabile CHC, Tiyani CHC and Livubu Clinic, also reported a lack of designated space. The provider at Livubu Clinic is forced to provide abortion services from her office due to the lack of designated space.

The failure to designate space for abortion services demonstrates the lack of prioritisation of termination of pregnancy services within facilities. Furthermore, it hampers the ability of service providers to provide counselling services to patients in a confidential and private manner, thereby compromising compliance with the Guideline.

Midlands Hospital further indicated that the abortion unit operates without an ultrasound machine and a vacuum aspirator. Settlers Hospital also reported that its abortion unit has no ultrasound machine. As a result, both facilities rely on a single ultrasound machine shared between the abortion unit, the maternity unit and the high-risk maternity unit. This significantly limits the number of women to whom abortion providers at these facilities can attend to per day.

While the Guideline provides that 'where an ultrasound is not available, clinical assessment of gestational age that agrees with LMP [last menstrual period] is acceptable', we note that medical professionals are reluctant to perform abortion procedures without an ultrasound. The reasons offered by the medical professionals we interviewed during our research allegedly relate to the requirements of their own professional bodies. For example, the nurses interviewed confirmed that they were trained in abdominal palpation and bimanual examination as methods of determining gestational age, but that the South African Nursing Council requires nurses to confirm gestational age using an ultrasound before performing a abortion.

[25] Section 5 of the Act.
[26] Abortion care guideline. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO 11.

On the face of it, there appears to be a conflict between the requirements of the professional body to which abortion providers belong and the expectations of the National Department of Health regarding the use of abdominal palpation and bimanual examination as alternatives to ultrasound. To the extent that this conflict exists, we recommend that the National Department of Health address the discrepancy with the relevant professional body. It is not enough for the state to provide a treatment option that does not require machines if medical professionals are barred from performing that option.

6. Staff shortages

Monitoring revealed that the main cause of the suspension of services at facilities with the requisite infrastructure is the failure of provincial health authorities to replace providers when they have been moved to other facilities, retired or refused to provide the service on religious or similar grounds. In Limpopo, services have been discontinued at the following facilities:

Motsepe Clinic - rovider retired in 2017 and was never replaced.

Nchabeleng CHC - the provider was moved to Jane Furse Memorial Hospital. Patients are referred to Dilokong Hospital, a travel distance of about 100 km per single trip and costing users approximately R120 per trip.

Boshoff CHC - the provider was on leave for three months during our monitoring and services were suspended indefinitely.

Matlala Hospital - the provider retired in 2023. Patients are referred to St Rita Hospital, a travel distance of about 70 km per single trip, costing users approximately R100 per trip.

Jane Furse Memorial Hospital - the previous provider resigned in 2023. Patients are now referred to St Rita Hospital, a travel distance of about an hour - 70 km - and users pay approximately R100 per single trip.

In the Eastern Cape, abortion services at Empilisweni CHC, Maluti CHC and Mount Ayliff CHC were discontinued due to a lack of service providers. The nurses at Empilisweni CHC reported that the facility receives cases of women requiring medical assistance due to incomplete abortions, which indicates the need for the service and suggests that women are turning to unsafe providers for abortion services.

Apart from Settlers Hospital, St Elizabeth Hospital and Andries Vosloo Hospital in the Eastern Cape, all the healthcare facilities monitored had only one TOP provider assigned, or previously assigned, to the TOP unit. Similarly, only three facilities in Limpopo have more than one TOP provider. All the facilities with single TOP providers reported that they are forced to turn away patients when the provider is on leave or absent.

Most of the abortion providers interviewed stated that they desperately require more staff in order to meet demand for the service effectively. This includes doctors to prescribe medication required by patients.

7. Medicine shortages

Four hospitals in the Eastern Cape, namely Midlands Hospital, Aliwal North Hospital, St Elizabeth Hospital and Settlers Hospital, reported occasional shortages of mifepristone. Shortages of mifepristone result in services not being offered to women seeking abortion services. This is despite the possibility of offering a misoprostol-only regimen (which has 85% effectiveness in terms of the Guideline). Although this is not the preferred regimen under the Guideline, it is nonetheless an effective option. The preferred method, the combined mifepristone-misoprostol regimen, has 95% effectiveness in terms of the Guideline. This 10% difference in effectiveness can be mitigated by reinforcing the availability of post-abortion care to women. Settlers Hospital and St Elizabeth Hospital rely on Cytotec in the absence of mifepristone, while Aliwal North Hospital offered only surgical abortions due to the drug shortages.

8. Inefficient referral systems

The monitoring process revealed a lack of standardised referral systems at facilities. Due to incorrect and outdated information on available facilities, women are referred to facilities that are no longer operational or where services have been suspended. For example, Makhuva Clinic and Mapayeni Clinic still refer patients to Nkhensani Hospital, which no longer provides abortion services.

RECOMMENDATIONS

Availability of Facilities

Our research suggests that it is highly unlikely that provincial departments of health are conducting audits of abortion facilities to determine whether the facilities designated on paper are equipped and operational in accordance with their obligations under the CTOP Act. We therefore recommend that both provincial departments conduct audits and publish a list of operational facilities annually, as required by the CTOP Act.

Conscientious Objection

The CTOP Act makes no provision for conscientious objection, and the National Department of Health has failed to regulate the practice. We therefore recommend the removal of the section relating to conscientious objection in the Guidelines, together with the provision of human rights training and sensitisation for healthcare professionals.

Delays in Care

The considerable delays experienced by women seeking abortion services, particularly at facilities providing second-trimester abortion services, are unacceptable and, in some instances, tantamount to a denial of service. The primary cause of delays, as noted by abortion providers and hospital administration at both hospitals, is the lack of resources.

It is unacceptable that women must travel to multiple health facilities before they are assisted due to long waiting periods. We recommend that both departments adopt a policy requiring the determination of gestational age at the first visit to the facility and that first-trimester abortion services be conducted at that first visit. Where a second-trimester termination is required, the woman must immediately be furnished with a referral letter to a second-trimester facility.

Equipment Constraints

There are clearly severe equipment constraints and shortages of space allocated for abortion services at facilities. The shortage of equipment contributes significantly to delays in care. We recommend that the Eastern Cape Department of Health dedicate an ultrasound machine to each designated facility. To the extent that the National Department of Health believes that alternative means of determining gestational age should be used, we recommend that it engage with the professional bodies of the medical professionals who work under it and establish a way forward.

Equipment Constraints (cont.)

We further recommend that the respective departments conduct an audit of its facilities to determine the number of beds available at each facility. Once this is done, we recommend that the provincial departments of health furnish each facility with enough beds to cater for the average number of abortion requests they receive, including beds for second-trimester abortion procedures and recovery beds.

Staff Shortages

Staff shortages are a major contributing factor to delays in care. More than 80% of the facilities visited had only one abortion provider. In the event of these providers' absence, women are unable to access abortion services. Additionally, the main contributing factors to the suspension of services at facilities are the unavailability of providers due to conscientious objection and the transfer of providers to other units. Both departments must ensure the timeous appointment or replacement of abortion providers and ensure that service provision is uninterrupted.

In the circumstances, we recommend that both departments conduct an audit of facilities to determine the demand on each facility and the related staffing requirements. We further recommend that IPAS be contracted again to train healthcare providers, as there is an evident gap in training.

Shortages of Medicines

Despite shortages of mifepristone, abortion providers appear reluctant to offer a misoprostol-only regimen. It is not immediately clear why this reluctance exists. Be that as it may, we recommend that the Eastern Cape Department of Health communicate to its abortion providers that a misoprostol-only regimen is also acceptable as a standard of practice. We believe that this will alleviate some of the waiting times caused by medical stock-outs of mifepristone, together with the post-abortion care that is required. We recommend that the Eastern Cape Department of Health monitor and address stockouts of the mifepristone at all abortion facilities.

Inefficient Referral Systems

For efficient referral systems to exist, there must be annual monitoring of designated facilities to establish the number of operational facilities. This annual audit must be shared with all facilities in order to ensure that TOP users are referred to the correct facilities.

CONCLUSION

> *The state of abortion services in the Eastern Cape and Limpopo falls far below the standard set out in the Act and the Guidelines and constitutes a violation of the constitutional rights of women to reproductive healthcare.*

The issues crippling abortion care in the provinces revolve specifically around a lack of equipment, staff shortages and the paucity of designated and operational second-trimester abortion facilities. These resource limitations contribute significantly, if not entirely, to delays in access to abortion services.

A delay of approximately three weeks in access to first-trimester abortion services may be the difference between requiring a first- and second-trimester abortion. A delay of approximately six weeks for second-trimester abortions could mean the difference between obtaining a safe and legal abortion and falling outside the gestational age limit provided for in the Act. These delays are avoidable and require the Eastern Cape Department of Health and Limpopo Department of Health to invest resources in abortion care.

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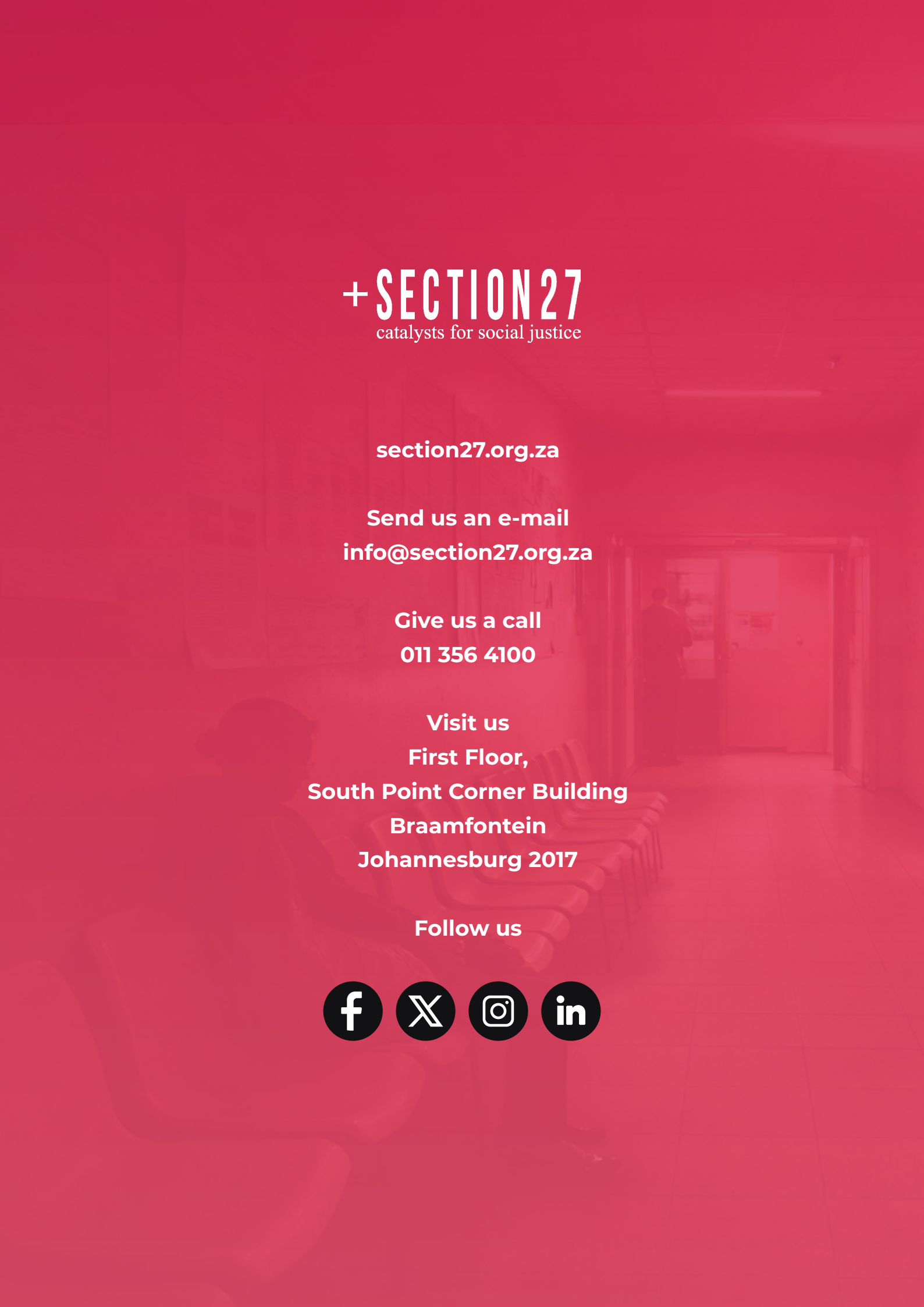

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